		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036947

Facility Name: GROUP HOME #1

Address: 212 BACHMAN LANE (Number) GODFREY (City) 62035 (Zip Code)

County: MADISON

Telephone Number: (618)466-0367 **Fax #** ( )

IDPA ID Number: 37-0765971001

Date of Initial License for Current Owners: 07/19/91

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 501(c)(3)

In the event there are further questions about this report, please contact:
Name: BRENDA MILLER **Telephone Number:** (618)466-0367

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARTHA WARFORD
(Title) EXECUTIVE DIRECTOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) KIMBERLY S. LOY, CPA, PRINCIPAL
(Firm Name & Address) SCHEFFEL & COMPANY, P.C., 106 COUNTY ROAD, JERSEYVILLE, IL 62052
(Telephone) (618)498-6841 Fax # (618)498-6842

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,094	443		5,537	13
14	TOTALS	5,094	443		5,537	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.81%

D. How many bed-hold days during this year were paid by Public Aid?
242 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/19/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/19/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	27,772	662		28,434	509	28,943		28,943			1
2	Food Purchase		24,361		24,361		24,361		24,361			2
3	Housekeeping	16,062	3,019		19,081		19,081		19,081			3
4	Laundry											4
5	Heat and Other Utilities			12,345	12,345		12,345		12,345			5
6	Maintenance	22,242	1,658	3,972	27,872		27,872		27,872			6
7	Other (specify):* SECURITY	77	86	7,064	7,227		7,227		7,227			7
8	**TOTAL General Services**	66,153	29,786	23,381	119,320	509	119,829		119,829			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	180,977	2,352		183,329	(5,071)	178,258		178,258			10
10a	Therapy			2,119	2,119		2,119		2,119			10a
11	Activities		1,446		1,446		1,446		1,446			11
12	Social Services			2,292	2,292		2,292		2,292			12
13	Nurse Aide Training					4,562	4,562		4,562			13
14	Program Transportation	4,814			4,814		4,814		4,814			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	185,791	3,798	4,411	194,000	(509)	193,491		193,491			16
	C. General Administration											
17	Administrative	25,117		33	25,150		25,150		25,150			17
18	Directors Fees											18
19	Professional Services			9,640	9,640		9,640		9,640			19
20	Dues, Fees, Subscriptions & Promotions			3,940	3,940		3,940		3,940			20
21	Clerical & General Office Expenses	25,457	1,982	2,117	29,556		29,556		29,556			21
22	Employee Benefits & Payroll Taxes			67,254	67,254		67,254		67,254			22
23	Inservice Training & Education											23
24	Travel and Seminar			422	422		422		422			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,615	41,615		41,615		41,615			26
27	Other (specify):*											27
28	**TOTAL General Administration**	50,574	1,982	125,021	177,577		177,577		177,577			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	302,518	35,566	152,813	490,897		490,897		490,897			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GROUP HOME #1 #0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,670	18,670		18,670		18,670			30
31	Amortization of Pre-Op. & Org.			1,136	1,136		1,136		1,136			31
32	Interest			37,756	37,756		37,756		37,756			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS			2,745	2,745		2,745		2,745			36
37	**TOTAL Ownership**			60,307	60,307		60,307		60,307			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,292	38,292		38,292		38,292			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			38,292	38,292		38,292		38,292			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	302,518	35,566	251,412	589,496		589,496		589,496			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GROUP HOME #1

ID# 0036947

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROUP HOME #1 # 0036947 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		BEVERLY FARM FOUNDATION	GODFREY, IL			
		GROUP HOME #2	GODFREY, IL			
		GROUP HOME #3	GODFREY, IL			
		GROUP HOME #4	GODFREY, IL			
		GROUP HOME #5	GODFREY, IL			
		GROUP HOME #6	GODFREY, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BEVERLY FARM FOUNDATION
Street Address:
City / State / Zip Code: GODFREY IL 62035
Phone Number: (618) 466-0367
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22-3	EMPLOYEE BENEFITS	WAGES	10,000	8	$ 1,579,388	$	253	$ 40,003	1
2	22-3	EMP BENEFITS (HEALTH INS)	EMPLOYEES	300	8	1,635,064		5	27,251	2
3	17-3	SCHOOL REIMBURSEMENT	WAGES	10,000	8	1,265		258	33	3
4	17-1	ADMINISTRATIVE SALARIES	DAYS/HOURS	2,080	8	253,491	253,491	104	12,675	4
5	21-1	PERSONNEL/ACCOUNTING	DAYS/HOURS	2,080	8	509,136	509,136	104	25,457	5
6	6-1	MAINTENANCE STAFF	DAYS/HOURS	2,080	8	444,840	444,840	104	22,242	6
7	7-3	SECURITY	DAYS/HOURS	2,080	8	141,272		104	7,064	7
8	7-1	GUARDS	DAYS/HOURS	2,080	8	1,539	1,539	104	77	8
9	7-2	SECURITY SUPPLIES	DAYS/HOURS	2,080	8	1,712		104	86	9
10	6-2	MAINTENANCE SUPPLIES	DAYS/HOURS	2,080	8	31,171		104	1,559	10
11	21-2	OSHA REQUIREMENTS	DAYS/HOURS	2,080	8	28,811		104	1,441	11
12	21-3	CONSULTANTS	DAYS/HOURS	2,080	8	8,736		104	437	12
13	6-3	STORM REPAIRS	DAYS/HOURS	2,080	8	2,098		104	105	13
14	26-3	INSURANCE	DAYS/HOURS	2,080	8	832,294		104	41,615	14
15	19-3	LEGAL & ACCOUNTING	DAYS/HOURS	2,080	8	192,803		104	9,640	15
16	14-1	TRANSPORTATION STAFF	DAYS/HOURS	2,080	8	96,274	96,274	104	4,814	16
17	20-3	DUES/SUBS/ADVERTISING	DAYS/HOURS	2,080	8	86,652		95	3,937	17
18	24-3	TRAINING	DAYS/HOURS	2,080	8	8,457		104	423	18
19	36-3	MORTGAGE INSURANCE	DAYS/HOURS	2,080	8	54,906		104	2,745	19
20	32-3	INTEREST	DAYS/HOURS	2,080	8	755,112		104	37,756	20
21	31-3	BOND AMORTIZATION	DAYS/HOURS	2,080	8	22,726		104	1,136	21
22										22
23										23
24										24
25	TOTALS					$ 6,687,747	$ 1,305,280		$ 240,496	25

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IL HEALTH FACILITY		X	CONSTRUCTION		07/96	$	$ 544,886	2031	6.6800	$ 36,595	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MISCELLANEOUS										1,161	6
7												7
8												8
9	TOTAL Facility Related						$	$ 544,886			$ 37,756	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 544,886			$ 37,756	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 2,745 Line # 36-3

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROUP HOME #1 COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0036947

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,112 B. General Construction Type: Exterior BRICK Frame MASONRY Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	10,000		$ 5,000	1
2					2
3	TOTALS	10,000		$ 5,000	3

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1991	$ 380,640	$ 9,516	40	$ 9,516	$	$ 122,915	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUS SHELTER			1996	188		5			188	9
10	ADMINISTRATION BUILDING			1997	55,609	1,391	40	1,391		10,431	10
11	CARPET			1998	4,510		5			4,510	11
12	HARDWARE			1998	546	55	10	55		329	12
13	SECURITY SYSTEM			1998	171	17	10	17		101	13
14	METER CHANGE			2000	1,230	246	5	246		1,107	14
15	NEW FLOORING			2000	1,625	325	5	325		1,463	15
16	ROAD WORK			2000	2,508	251	10	251		1,129	16
17	NEW FLOORING			2001	2,585	143	5	143		1,435	17
18	FIRE ALARM PANEL			2002	3,109	311	10	311		466	18
19	DIGITAL THERMOMETER			2003	777	78	10	78		117	19
20	DOOR AND FRAME REPLACEMENT			2004	3,219	161	10	161		161	20
21	FLOORING			2004	3,726	373	5	373		373	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 460,443	$ 12,867		$ 12,867	$	$ 144,725	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 20,588	$ 2,829	$ 2,829	$	5-10	$ 14,731	71
72	Current Year Purchases	9,441	638	638		5-10	638	72
73	Fully Depreciated Assets	32,489					32,489	73
74								74
75	TOTALS	$ 62,518	$ 3,467	$ 3,467	$		$ 47,858	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	SCHEDULED	SEE SCHEDULE	VARIOUS	$ 28,505	$ 2,336	$ 2,336	$	5	$ 15,616	76
77										77
78										78
79										79
80	TOTALS			$ 28,505	$ 2,336	$ 2,336	$		$ 15,616	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 556,466	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,670	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 18,670	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 208,199	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	64

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		100		100
3	Classroom Wages (a)		1,830		1,830
4	Clinical Wages (b)		2,288		2,288
5	In-House Trainer Wages (c)		343		343
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 4,562	$	$ 4,562
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,562			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,304,481		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,304,481	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	460,443		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	91,023		16
17	Accumulated Depreciation (book methods)	(208,199)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 348,267	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,652,748	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	544,886		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 544,886	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 544,886	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,107,862	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,652,748	$	48

*(See instructions.)

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,048,490	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,048,490	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	59,372	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 59,372	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,107,862	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 648,868	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 648,868	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 648,868	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	119,829	31
32	Health Care	193,491	32
33	General Administration	177,577	33
	B. Capital Expense		
34	Ownership	60,307	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 589,496	40
41	**Income before Income Taxes (line 30 minus line 40)****	59,372	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 59,372	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	17,740	18,832	163,879	8.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,671	3,087	28,281	9.16	15
16	Dishwashers					16
17	Maintenance Workers	1,701	1,916	22,242	11.61	17
18	Housekeepers	2,054	2,054	16,062	7.82	18
19	Laundry					19
20	Administrator	653	684	16,966	24.80	20
21	Assistant Administrator	97	107	2,958	27.64	21
22	Other Administrative	259	290	5,547	19.13	22
23	Office Manager					23
24	Clerical	1,848	2,090	25,102	12.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	731	773	16,590	21.46	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	425	500	4,891	9.78	33
34	TOTAL (lines 1 - 33)	28,179	30,333	$ 302,518 *	$ 9.97	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	107	2,119	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	92	2,292	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	199	$ 4,411		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA WARFORD	EXECUTIVE DIRECTOR	0	$ 4,524
VICKY PALMER-VOGT	ASSISTANT DIRECTOR	0	2,958
BRENDA MILLER	CONTROLLER	0	2,174
THOMAS SCHNELL	PERSONNEL MANAGER	0	3,019
RACHEL LOLLIS	ADMINISTRATOR	0	12,442
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 25,117

B. Administrative - Other

Description	Amount
SCHOOL REIMBURSEMENT	$ 33
TOTAL (agree to Schedule V, line 17, col. 3)	$ 33
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED &		$
ALLOCATION WORKSHEET	LEGAL FEES	7,135
SCHEFFEL & COMPANY, P.C.	ACCOUNTING & AUDITING	2,505
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,640

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,237
Unemployment Compensation Insurance	3,569
FICA Taxes	22,754
Employee Health Insurance	27,251
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	3,096
MISCELLANEOUS BENEFITS	5,347
TOTAL (agree to Schedule V, line 22, col.8)	$ 67,254

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	903
Health Care Worker Background Check	133
(Indicate # of checks performed 13)	
DUES, SUBS, LICENSES, FEES	2,904
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,940

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	422
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 422

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GROUP HOME #1 # 0036947 Report Period Beginning: 07/01/03 Ending: 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS HEALTH CARE $574

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 38,292
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: SCHEFFEL & COMPANY, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

GROUP HOME #1 #0036947
VEHICLE DEPRECIATION - SCHEDULE XI., Section D.
JUNE 30, 2004

Use	Model, Make, Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Depreciation
RESIDENT TRANSPORTATION	95 CHEVROLET VAN (1/3)	1995	5,610		-		5,610
RESIDENT TRANSPORTATION	95 CHEV. CORSICA (1/3)	1995	4,189		-		4,189
RESIDENT TRANSPORTATION	CAPITALIZED REPAIRS	2000	4,656	931	931		4,190
RESIDENT TRANSPORTATION	(2) 2002 FORD VANS	2002	4,436	444	444		666
RESIDENT TRANSPORTATION	NEW FORD VAN	2003	1,442	144	144		144
RESIDENT TRANSPORTATION	CHEVY CAVALIER	2003	76	8	8		8
MAINTENANCE	FORD TRUCK	2003	299	30	30		30
RESIDENT TRANSPORTATION	IDOT BUS	2004	4,643	464	464		464
MAINTENANCE	F350 PICKUP	2003	1,329	133	133		133
WHEEL CHAIR VAN	WHEEL CHAIR VAN	2004	1,825	183	183		183
	TOTALS:		$ 28,505	$ 2,336	$ 2,336	$ -	$ 15,616

GROUP HOME 1 #0036947
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2004

	1	2	3	4
SERVICE	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
SECURITY	1	14	$ 77	5.50
TRANSPORTATION	424	486	4,814	9.91
	425	500	$ 4,891	

BEVERLY FARM FOUNDATION
REALLOCATION OF GH ADMINISTRATOR TO GH QMRP (DIRECT CARE)
6/30/2004

ACCOUNT #	DESCRIPTION	WAGES PER TB	RECLASS (OJE)	PER COST REPORT	HOURS PER SPREADSHEET		RECLASS		PER COST REPORT	
					REGULAR	VACATION	REGULAR	VACATION	REGULAR	VACATION
8250R0	GH 1 ADMIN	20,737.08	(8,294.83)	12,442.25	914.30	52.00	(365.72)	(20.80)	548.58	31.20
8250S0	GH 2 ADMIN	20,737.08	(8,294.83)	12,442.25	914.30	52.00	(365.72)	(20.80)	548.58	31.20
8250T0	GH 3 ADMIN	19,093.73	(7,637.49)	11,456.24	972.00	83.00	(388.80)	(33.20)	583.20	49.80
8250U0	GH 4 ADMIN	19,093.73	(7,637.49)	11,456.24	972.00	83.00	(388.80)	(33.20)	583.20	49.80
8250V0	GH 5 ADMIN	21,174.88	(8,469.95)	12,704.93	877.00	219.40	(350.80)	(87.76)	526.20	131.64
8250W0	GH 6 ADMIN	21,174.88	(8,469.95)	12,704.93	877.00	219.40	(350.80)	(87.76)	526.20	131.64
8252R0	GH 1 QMRP	-	16,589.66	16,589.66	-	-	731.44	41.60	731.44	41.60
8252S0	GH 2 QMRP	27,223.88		27,223.88	2,008.00	72.00			2,008.00	72.00
8252T0	GH 3 QMRP	25,601.89		25,601.89	1,738.77	291.40			1,738.77	291.40
8252U0	GH 4 QMRP	-	15,274.98	15,274.98	-	-	777.60	66.40	777.60	66.40
8252V0	GH 5 QMRP	31,314.75		31,314.75	1,920.00	200.00			1,920.00	200.00
8252W0	GH 6 QMRP	-	16,939.90	16,939.90	-	-	701.60	175.52	701.60	175.52
	Totals:	206,151.90	-	206,151.90	11,193.37	1,272.20	-	-	11,193.37	1,272.20

There are three group home administrators. In the group homes that have a physical administrator office (#1,4,6), the administrator also serves as the QMRP. In those homes, 80% of the administrators' time is spent on QMRP duties.